UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ALASKA

KIMBERLY ALLEN, Personal Representative of the ESTATE OF TODD ALLEN, Individually, on Behalf of the ESTATE OF TODD ALLEN, and on Behalf of the Minor Child PRESLEY GRACE ALLEN,

Plaintiffs,

vs.

UNITED STATES OF AMERICA,

Defendant.

_____/

Case No. A04-0131 (JKS)

VIDEOTAPED DEPOSITION OF RICHARD E. BRODSKY, M.D.

Pages 1 - 147, inclusive

Monday, April 11, 2005, 8:05 a.m.

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don't think there's specific guidelines different than you would have for a physician who has, you know, rules and regulations in terms of standards of practice and stuff.

Q. Okay.

A. So I don't know of any particular State licensing guidelines.

Q. Okay. And don't be distracted by my words.

A. Yeah.

Q. If I use a word and you haven't used it, and it doesn't seem right to you, then --

A. Sure.

Q. -- please -- please correct me.

A. I will.

Q. What is the role of the ANPs? And ANP is -- I'm saying is Advanced Nurse Practitioner?

A. Uh-huh.

Q. What role do they play in the emergency department?

A. Nurse practitioners in the emergency department work in our urgent care arm of the department, and so they see patients independently who are triaged to that side of our operation.

Q. Okay. And then you said the -- the urgent care center arm. If you could just describe for me

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then basically -- let me go back to the structure of the emergency department.

A. Sure.

Q. How is it structured?

A. Sure. The department is structured in a way that begins at the check-in triage area. To understand how the emergency department works, you have to really go to that area where a patient presents to be seen in -- in one of two ways.

They either walk in and come to the front area of the department or they come in the back by an ambulance or other vehicle. And so people who come in by ambulance are almost always seen by the physicians in the department, go to a bed directly, and register and things are taken care of there.

The patients who come to the front of the department and request to be seen are immediately assessed by our triage nurse. There's nursing personnel that evaluate the level of urgency. So it's a person who does a brief assessment of why they're there. Usually takes their vital signs and other information and determines how urgent it is and how to categorize them.

We have a five-level triage system that puts people in Level 1 to 5 based on their level of

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illness, the acuity of their illness, how urgent it is to see them, and with 1 being the highest level and 5 being the lowest level.

And so a patient comes in, checks in, gets assessed. They first might give their name to the clerk at the front desk so can start a chart. Then they're immediately triaged without delaying care.

And then if they're in a high level of triage, they may go directly back to a bed and be registered there in the bed. If they're a lower level, they may go back and sit in the -- in the waiting room and have a registration occur while they're waiting to be seen by a provider. And then they'll be called in to be seen.

The people who are triaged to our lower levels are usually placed -- their charts are placed in the urgent care rack. People in the higher levels of triage will be placed in the physician rack. And -- and then we see people generally in order unless somebody sicker comes in, you know. And the workload is kind of split between the physicians seeing the sicker patients and the mid-level practitioners seeing the less acutely ill patients in what we call urgent care.

Q. Okay.

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A. Now sometimes physicians also see patients in -- from the urgent care rack. Depends if they're not busy. They'll take patients off the rack. Or if we feel -- that provider sees the patient, feels that -- that it's beyond their skill level or that they need a consultation, they may move them to the physician rack, based on their assessment.

We have some combined nursing functions and some separate functions, so we have registered nurses who do triage. We have -- excuse me -- LPNs who -- licensed practical nurses who work in the urgent care side and registered nurses who work in the emergency room side. And then we have emergency room technicians who also work in the emergency room side supporting the care.

Q. Okay. And the license -- what -- what's the difference between the RNs and the licensed nurse practitioners?

A. It's education, licensing, skill set. And registered nurses can either have a two- or four-year degree. And LPNs, I'm not sure if it's one year or one and a half years or what it is, but they -- their skill set is less, and they can do less than registered nurses.

Q. Okay.

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to make often. And if you look at the literature again, you will find that most people who present with subarachnoid hemorrhage are not diagnosed when they first present, or a substantial portion of them are not. And so it's something that often doesn't present overtly with the obvious signs and symptoms that leads somebody to the diagnosis.

So if someone comes in with the worst headache of their life, that suddenly came on, and a stiff neck, you know, you're much more likely to say subarachnoid hemorrhage than somebody who comes in and says, I have a headache, or, you know, I'm nauseous or, you know, I'm -- you know, don't feel right. And so that many patients -- or even most patients who are initially seen are not diagnosed.

And the diagnosis requires, you know, imaging techniques or lumbar puncture, and so one has to make the leap to suspicion to do those things, and so probably a lot of people are missed.

Q. Okay. I wanted to ask you about imaging techniques --

A. Uh-huh. Sure.

Q. -- and technology --

A. Sure.

Q. -- in the emergency department.

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A. Sure.

Q. Do you have -- I -- I'm going to take it you have got CT scans.

A. Twenty-four hours a day.

Q. Twenty-four hours a day. And was that the case in 2003?

A. Yes.

Q. All right. And what generation of technology is it?

A. At that time, I don't know the -- I can't tell you which scanner it was at that time. You know, we've upgraded since then to a 16-bit, you know, technology. So it was the previous technology. But certainly the resolution was enough to show subarachnoid hemorrhage and, you know, that's what we used as our --

Q. Oh, sure. Okay.

A. -- technique, you know, at the time.

Q. And then did you have arteriograms?

A. We do not have arteriograms available in the hospital. So if we need to do an arteriogram, we would -- at that time?

Q. Yeah.

A. Of course it's a different era now. With our new scanner, we have CT and geography available,

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and so it's a little bit upgraded with this generation. But in that time period, we didn't have CT and geography capability. So if somebody was determined to need an angiogram, we would have made arrangements to transfer them to Alaska Regional Hospital and have the angiogram done there.

Q. And is there a difference between an angiogram and an arteriogram?

A. Same.

Q. Are they the same thing?

A. Same.

Q. Okay. So in 2003 you had CT technology and then -- and if -- and if somebody needed an angiogram, arteriogram, you would send them over --

A. Right.

Q. -- to Alaska Regional?

A. Right, uh-huh.

Q. Okay. Got it. And then now there's been some upgrades in technology and things?

A. There's upgrades in technology, in terms of having CT/angio capability. The resolution is not as good as a full, you know, core angiogram, and, you know, most neurosurgeons, if they're going to operate on somebody with a subarachnoid hemorrhage who might have an aneurysm, they would want to do an angiogram

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first. They want --

Q. Sure.

A. -- want to get better verification of the site and determine, you know, what their approach is going to be. And they may even, with some subarachnoid hemorrhages in this day and age, particularly in the posterior circulation, they'll do angiography and coilings so that you can avoid doing a craniotomy. And so -- and that's not done in Alaska right now.

So -- and so our policy -- and I knew you were going to get to this. I might as well tell you now. Generally then, and continues to be now for most people with subarachnoid hemorrhage, most of our patients end up going to Seattle --

Q. Okay.

A. -- for subarachnoid hemorrhage definitive diagnosis and treatment. And back at that time, we were still sending many of those patients to Alaska Regional for an angiogram first before we made the decision as to whether they would go to Seattle --

Q. Okay.

A. -- or stay here in Anchorage. Today, even though we have a neurosurgeon on our own staff right now, we're sending all the patients to Seattle, and